

## Letter from Germany

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### The scene

Over 60 million Germans are serviced by 130 000 physicians (1:460), with a characteristic maldistribution of medical resources to the detriment of poor, isolated and otherwise unattractive areas. The Federal Republic of Germany spends 10.2 per cent of its GNP on health, but has an infant mortality rate that is slightly higher and a somewhat lower life expectancy than, for example, Great Britain.

About half of all German doctors are in private practice, most of them having no affiliation whatsoever to any clinical institutions. The vast majority of those physicians working in hospitals are under temporary contracts and stay only for the period of years required to obtain specialty certification, before going into private practice. The permanent medical staff of clinics and hospitals is thus reduced to chairpersons, department and clinic heads and investigators supported by strongly funded grants, most of these individuals having the academic rank of full professors. Thus, academic medicine is represented and nourished by a small minority of high ranking physicians and scientists, whereas most doctors have only sporadic or temporary access to academic facilities. This structure implies that only a very small percentage of doctors will live off a salary for longer than a few years, it being understandable that vested interests in lucrative medical activities should prevail among physicians (1).

All physicians are required to become paying members of their medical association and must subscribe to its pension fund. This affiliation is not only mandatory, it is unassailable. Criticism of medical associations or deviations from official syndicate politics may lead to professional sanctions of consequence.

### The roots

In reading some of what has been published over the years, one can hardly overlook two general and cardinal aspects of German thought on medical ethics. The most recurrent theme is that of duty (to the patient, to colleagues, to the medical establishment, to society), giving rise to a widespread, if somewhat rigid elaboration of medical deontology. The second theme, slightly more subdued, is that of the patient as a needy human being. Physician's duty and patient's need seem to be rooted in the philosophical thought of Kant and

Nietzsche, a hypothesis that is easy to come by, even though hard to demonstrate, when noticing how often these two thinkers are mentioned in the German medico-ethical literature.

Kant's devotion to the idea of duty is well known and need not be elaborated here. Dutiful acts occur in accordance with the categorical imperative that requires each act to be based on a maxim sound enough to be acceptable as a general law of conduct. Kantian duty is immanent in its finality, independent of its effects and hermetic in character. Duty is not derived from the nature or experiences of human beings. It is purely rational, impermeable to external influences and eminently non-utilitarian (2).

Thus understood, deontology constitutes a bulwark for firm, secure and determined systems of ethical thought and action. It supports paternalistic, even authoritarian patterns of relationships and can be impervious to any criticism or change.

Approximately at the same time that Kant was writing his *Fundamentals of the Metaphysics of Morals*, W F Rau was coining the term medical police, meaning that medicine was one of the disciplines concerned with politics or governmental administration. The idea of medicine as a branch of politics turned out to be more appealing to the German mentality and fitted better its political and economic reality than was the case in France, Great Britain or the USA. A profusion of publications demonstrate this interest and culminated in the gigantic work of J P Frank on medical police, which gave birth to the disciplines of public health and social medicine (3), (4). In the same vein Virchow, in a widely cited passage written somewhat later, considered medicine to be a social discipline and politics to be no more than medicine on a larger scale.

An important part of the writings expounding the idea of medical police distinguished natural from man-made diseases and imputed the latter to moral laxitude of which the diseased person was either guilty or a victim. This moral genesis of disease recurs frequently during the Romanticism, especially in conjunction with theologic thought. Thus, disease is related to sin (5), to lustful desires and a savage soul (6), to direct action of the devil (7) or, as propugned by a contemporary professor of medicine, again to sin or to the call of God (8).

Kant's deontology, the concept of medical police and the metaphysical notion of disease all have one aspect in common: the agent is in possession of the

truth and can pass accurate moral judgment upon the patient.

Nietzsche had little good to say about the anaemic philosophy of Kant. To him, morality was no more than a question of strategy and quest for power, a way of making humans predictable and manageable. The idea of duty, he stated, had been long and thoroughly bathed in blood. This image had to be particularly repellent to Nietzsche, who hated suffering because it was so senseless. And he considered suffering, specifically in the form of disease-proneness, to be the price humankind pays for its power to domesticate nature (9).

All events occurring in the organic world aim at conquering and overpowering resistances, a risky process full of morbid perils. Whoever falls prey to disease can no longer satisfy his organic impulse to struggle and becomes needy. Fitness is essential to survival. Nietzsche's writings all burst with energy, with visions of organic forms constantly breaking the constraints of nature and of pulsating life overpowering the more ascetic, adynamic and conservative forms of being. Nietzsche, a sick man throughout his short life was all too conscious of the weaknesses and needs of the diseased.

The double concept of disease as an accident in the struggle for life and as a state of insufficient vitality, breaks with the tradition of seeing illness as a value-free deviation from the norm as established in the 19th century (10), (11), and helps flesh out the notion of patients as needy beings requiring assistance. Disease as a state of need and a request for help was stressed in Germany during the 20th century by initiators of anthropologic medicine, notably von Weizsäcker (12) and, later, von Gebattel (13), as well as by other psychiatrists concerned with establishing a medical anthropology that would not neglect the personal dimension of the diseased human being.

Two paths bring us to the present scene of German medical ethics. On the one hand, Kant's deontology and the social control agencies represented by medical police and theologic thought, all of which place the patient in a plane of social and moral inferiority, confronted by a physician sanctioned by deontologic conviction, social certification and moral certitude. On the other hand, leading from Nietzsche, there runs a thread of sympathetic but outright debasement of the patient, recognising him as biologically unfit, anguished, needy and help seeking. Both Kantian thought and Nietzschean vitality have been instrumental in creating the image of a physician protected by moral, social and biologic integrity, and a patient deficient in one or all of these graces.

### The themes

Two problems seem to best illustrate some cardinal aspects of medico-ethical thought in contemporary

Germany: euthanasia and the physician-patient relationship.

Since the 19th century, and initially based on Darwin's thesis of survival of the fittest, the German literature presents an outspoken and merciless defence of the destruction of underprivileged life. Weak, unhappy and superfluous beings may be eliminated or at least prevented from reproducing themselves (14). At the turn of the century, a number of essays were honoured which questioned or condemned society's protection of the poor, the sick, the lazy, drunkards and the physically or psychologically disabled (15), (16), (17). Out of this defence of collective against individual interests, there slowly evolved the initially limited concept of euthanasia in the sense of mercy-killing of incurable and willing patients. Interestingly enough, the first pleas to legalise euthanasia came from severely handicapped laypeople, not from physicians (18).

Weighty scientific publications pleaded for the legalisation of euthanasia in cases of incurable diseases, profound mental deficiency and coma. The impossibility of mental incompetents to participate in the decision was ignored and some papers based on these ideas even suggested eliminating 'ballast existences', 'weaklings of all sorts' or 'defective humans' (19), (20).

These concepts have been branded social Darwinism, when in fact they are purely Nietzschean. Nietzsche specifically disregarded the Darwinian thesis of organic adaption to environmental stimuli. To him, organic matter was not meekly adapting in order to survive, but was rather imbued and intoxicated with an immense will for power and a desire to dominate. This almost metaphysical vision of organic matter in quest of power seems to underlie the whole discussion of euthanasia in Germany during the period 1880-1930.

The point to be stressed here is the uninhibited rhetoric in favour of stringent criteria to promote death not only among those irretrievably sick who wish to shorten their agony, but also among those who are considered too disabled to be cared for by society. The domino theory espoused by euthanasia opponents, contending that permissiveness might lead to abuse, had its tragic confirmation during the period 1933-45, when the term euthanasia was distorted to justify torture, crime and monstrous experimentation with humans (21).

Post-World War II Germany was reluctant even to employ the word euthanasia, let alone discuss the concept or permit death assistance. It is hardly surprising that even present day defence of euthanasia is very careful and subdued. Passive euthanasia is accepted and legally sanctioned, but here again one is confronted with writers who consider it a strictly medical decision to interrupt 'inappropriate' terminal therapy, but hardly discuss the desires of the patient or his proxy in regard to continuation or interruption of therapy, until death

is imminent and treatment becomes, by definition, inappropriate (22).

Active euthanasia is radically condemned and legally punished. The basic arguments against it are circular: no normal person wishes to die and if a critically ill person utters such a desire, he is not emotionally competent (23). Also, it is argued, euthanasia reopens the dangers of a domino effect, so that usage is limited for fear of abuse.

Last year, 1980, saw the birth of a new German periodical, *Physician and patient*, sub-titled *Journal of cooperation*. Its first articles outlined the orientation of the publication. Their central issue was patient non-compliance. The desired solution to this widespread problem is to reach compliance, that is, to counteract the patient's insufficient or lacking cooperation by improving doctor/patient relationships (24). The patient's non-compliance is seen as a revenge for being neglected by the physician and most authors agree that satisfactory compliance can be reached by giving more information to the patient (25).

Since compliance means consumption of pharmaceutical products, it is hardly surprising that medical directors of the pharmaceutical industry should have joined the chorus of complaints about non-compliance, bringing forth suggestions to improve compliance through various forms and techniques of patient information as well as control of medication uptake (26, 27). The doctor's most influential weapon against non-compliance is his pedagogic persuasion of the patient, a decidedly elitist and paternalistic attitude which in no small degree is nourished by the very anti-McKeownian belief that medicine was the decisive factor in defeating diseases, increasing organic fitness and augmenting longevity (28).

In all these debates it is ignored that non-compliance need not reflect insufficient information, but may signify disconformity with the physician or disharmony between medical and the patient's personal values. Equally neglected remains the view that informing and controlling a patient in order to increase his compliance implies a great amount of manipulation and indoctrination. Medicine as the possessor of truth and efficacy, it seems, upholds the physician's sense of duty to preserve what he deems to be physical fitness and a worthwhile life. This unrelenting, duty-bound attitude is certainly reminiscent of Kant's deontologic rigidity, at the same time containing elements of Nietzschean contempt, or at least condescension, towards the diseased and disabled.

### The outcome

The most prevalent medico-ethical stand to be found in contemporary German medico-ethical literature is very conservative. Informed consent finds only sub-total acceptance (29), (30), passive

euthanasia encounters limited adherence and ambiguous legal support, active euthanasia is rejected. Suicidal attempts are thoroughly thwarted and suicidally prone individuals are declared incompetent to decide their own demise (31). Abortion has been legally permitted, but on a so limited scale that no more than 10 per cent of desired pregnancy interruptions can be carried out under currently prevalent guidelines (32). These guidelines, moreover, are formulated in such a way that abortions are decided by the physician, not by the pregnant woman. Physician's arguments against the socialisation of medicine are uniformly derogatory and any proposition designed to increase governmental control of medical institutions or practices is fiercely combatted and condemned to be still-born (33).

It is unthinkable that medico-ethical thought in Germany should turn at present to the sophisticated themes being discussed in other countries, such as the right of homosexual couples to raise children (34), the permissibility of infanticide based on the concept of person (35), the utilitarian justification of torture (36) or the delicensure of physicians (37).

Medical ethics are taught only sporadically in a small number of medical schools and constitute neither an obligatory nor a very popular course. There is no chair for medical ethics in Germany, let alone an institute, centre or society for the study of medical ethics. The discipline is taught by professors of medicine trained in psychiatry, history of medicine or the basic sciences, as well as by professors of theology. Philosophers, ethicists or socio-culturalists devoted to medical ethics are practically unheard of (38).

Only very few periodicals are open to medico-ethical themes and most of them are printed by publishing houses with strong religious affiliations or directly connected to the medical establishment. Most articles dealing with ethical issues in medicine are signed by professors of medical or theologic faculties, some of them internationally known and members of prestigious editorial boards. They write with extensive knowledge of history and philosophy, are graceful and convincing in the use of the language and show a tendency to be normative and imperative, rarely descriptive and almost never analytical. Medical oaths and declarations are highly respected, often commented upon and usually praised, and this legalistic approach serves to dismiss a more thorough analysis of the subject under debate.

Obviously, a system favouring the expression of those who by position or conviction will defend it, has led to a reaction that searches for its own channels of communication. Some popular books have been published and widely read, all of them aimed at marring the image of doctors and medical institutions. Under titles like *Careful, doctor*, *The medical syndicate* or *The white magicians*, the authors have presented a very negative, perhaps too shrill

but undoubtedly well-documented picture of medical practices in Germany (39), (40), (41). Special targets of these unflattering publications were financial greed and deficient qualification of physicians, political and economic power of professional associations and excessive image polishing of medical institutions. These popular criticisms have been supported by sociological studies that aimed to show, in a well researched but perhaps politically biased manner, that social institutions and the medical establishment act in collusion for their benefit but at the expense of the individual.

A polarity has thus ensued with two embittered antagonists. Highly reputed, academically well situated physicians defend medical institutions, professional practices and the social order, supported by medical officials, theologians and right-wing politicians. The iconoclastic position is represented by sociologists and other members of the human sciences, as well as journalists, lay-people and younger physicians in training. Little basis for understanding or for a fruitful exchange of ideas can thus ensue, and the discussion of medico-ethical issues must under these circumstances remain feeble and colourless.

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